otherwise eligible to receive a visa, may be issued an immigrant visa upon receipt of notice by the consular officer of the giving of a bond or undertaking, as provided in section 221(g) of the Act, if the consular officer is satisfied that the giving of such bond or undertaking removes the alien's ineligibility to receive a visa under this section of the law.

* * * * *

Effective date. The amendments will become effective on October 20, 1975.

(Sec. 104, 66 Stat. 174; 8 U.S.C. 1104)

Dated: September 2, 1975.

For the Secretary of State.

LEONARD F. WALENTYNOWICZ,
Administrator, Bureau of Security and Consular Affairs, Department of State.

[FR Doc.75-24472 Filed 9-12-75;8:45 am]

Title 29—Labor

CHAPTER XXVI—PENSION BENEFIT GUARANTY CORPORATION

PART 2604—NOTICE OF INTENT TO TERMINATE

Purpose, Scope, Requirement of Notice

On July 14, 1975 the Pension Benefit Guaranty Corporation ("the PBGC") published for comment in the FEDERAL REGISTER, 40 FR 29555, proposed regulations pertaining to the Notice of Intent to Terminate required to be filed with the PBGC pursuant to § 4041(a) of the Employee Retirement Income Security Act of 1974 ("the Act"). The PBGC received several comments on the proposed regulations and has given consideration to each of them in promulgating these final regulations. As set forth in greater detail below several of the recommended changes have been implemented, but others have not. In addition, these final regulations contain technical changes from the proposed version and some substantive changes initiated by the PBGC staff.

A number of the comments received focused on the large amount of information required to be submitted with the Notice of Intent to Terminate and the expected difficulty of some plans in gathering all the information and filing it in a timely manner under the regulations. In response to these comments several changes have been made in the final regulations. The final regulations do not require the submission of all amendments to the plan, but rather only those plan amendments adopted or effective within the 5-year period preceding the proposed date of termination (§ 2604.4(b)(11)). The proposed regulations required the submission of copies of all requests for determination submitted to the Internal Revenue Service since the establishment of the plan. The final regulations only require submission of a request for determination relating to the termination of the plan (§ 2604.4(b)(18)). Consistent with this change in the regulations, the final regulations no longer require the submission of all letters of determination issued by the Internal Revenue Service. Rather they require merely the submission of the initial letter of determination, any letters relating to the disqualification and subsequent requalification of the plan and any letters of determination pertaining to the termination of the plan (§ 2604.4(b)(19)). Further, the table contained in § 2604.4(b)(20) of the final regulations has been simplified. The proposed regulations (§ 2604.3(b)(19)) required a breakdown of the data on retired and disabled participants by the type of benefit they are receiving. The final regulations simply require figures on the total number of retired and disabled participants and the aggregate amount of monthly benefits paid to such participants.

In addition to the changes discussed above, which should minimize the burden placed on the plan administrator in filing the Notice of Intent to Terminate, it should be noted that the proposed regulations contained a provision, § 2604.3(c), which allowed the plan administrator to request an extension of time to file or a waiver of the obligation to file any of the information required to be submitted with the Notice. This provision has been expanded in the final regulation to make clear that if the PBGC grants such extension or waiver, the Notice will be deemed to be complete when filed and shall not be voidable by the PBGC (§ 2604.4(c)). Moreover, a provision has been added, § 2604.4(d), stating that whenever the plan administrator requests an extension of time to complete the filing of the Notice, he shall also submit a signed agreement in which he agrees that if the PBGC grants such request, the 90-day period set forth in § 4041(a) of the Act, during which time assets of the plan may not be distributed pursuant to the termination of the plan, shall be automatically extended for an amount of time equal to the extension of time granted by the PBGC. It was believed necessary to add this provision so as to insure that the PBGC will have the full statutory 90-day period in which to make the required determination regarding the sufficiency of the plan's assets.

Some comments noted that certain of the information required to be submitted, i.e., that relating to compensation contained in requests for IRS determinations, is barred from public disclosure (see § 6104(a)(1)(C) of the Internal Revenue Code of 1954). In general, the PBGC believes that the Notice of Intent to Terminate and the information submitted therewith will be subject to public disclosure under the Freedom of Information Act, 5 U.S.C. 552. It is recognized, however, that in certain limited situations some of the information may not be required to be disclosed. In addition to the information relating to compensation referred to above, it is possible that the statement of the reason for terminating the plan (§ 2604.4(d)(22)) might, in some cases, contain confidential commercial or financial information which would be exempt from disclosure pursuant to paragraph (b)(4) the Freedom of Information Act, to assist the PBGC in determining whether any portion of the filing may not be disclosable a new provision, § 2404.4(b)(25), has been added, which requires the plan administrator state whether he believes any of the information submitted with the Notice is not disclosable under the Freedom of Information Act, to specify such information and to state the grounds for his belief.

A number of groups suggested that the plan administrator be required to deliver a copy of the Notice of Intent to Terminate to the union representative of the affected employees. The PBGC believes, with certain reservations noted below, that, as modified, this is a good suggestion. Accordingly, the final regulations require at § 2604.3(e) that immediately upon the filing of a Notice with the PBGC the plan administrator shall give written notification of this fact to the affected employees. The notification need simply state the date on which the Notice of Intent to Terminate was filed with the PBGC and the date of termination of the plan proposed therein. The PBGC believes it would be unduly burdensome to require the plan administrator to transmit all of the information required to be filed with the Notice to the employees or their bargaining representative. Employees or union representatives who wish to see the entire filing may request it from the PBGC pursuant to the Freedom of Information Act, and it will be made available in accordance with the regulations of the PBGC issued thereunder, 29 CFR 2603.

Delivery of the notification to the employees may be accomplished in one of two ways:

1. If the employees are represented by a union, the notification shall be delivered to the union representative; and

2. If the employees are not represented by a union, the notification shall be posted in a location or locations normally used by the employer for posting notices to employees.

Several questions and comments were received relating to the information on "active participants" required to be submitted pursuant to § 2604.4(b)(20). The final regulations do two things to clear up the apparent confusion. First, that term as it is used in § 2604.4(b)(20) is defined in § 2604.2. Second, the first item in the table contained in paragraph (20) referred to above has been amended to read "Active participants without vested rights."

There were suggestions made that the information required to be submitted under § 2604.4(b)(15) and (16) may not be recent enough to be of value to the PBGC. The PBGC recognizes that this, indeed, may be true in some cases. However, we believe that a rule that would require that an actuarial statement and a financial statement be prepared in connection with the filing of the Notice would be unduly burdensome. Where the PBGC believes that the information it has received under paragraphs (b)(15) and (16) is not adequate for its needs, the PBGC will require the submission of more up-to-date information.

Some confusion was expressed regarding the statement required to be made

under § 2604.4(b)(24) as to the sufficiency of the plan assets. Accordingly, that provision has been amended to make it clear that the statement goes to whether the plan assets are believed to be sufficient to satisfy all nonforfeitable benefits under the plan other than those benefits which become nonforfeitable solely because of the termination of the plan.

Finally, as noted above, certain technical and clarifying changes have been made in the regulations. Among the most important is that the language of § 2604.4(b)(4) has been made more explicit with respect to the nine-digit Internal Revenue Service Identification Number required to be reported under that paragraph, and the second part of that paragraph pertaining to the three-digit Plan Number has been set off as a new paragraph (b)(5) or § 2604.4. The subsequent paragraphs of that section have been re-numbered accordingly. Further, a new § 2604.2, "Definitions," has been added, and the subsequent sections of the regulations have therefore been re-numbered.

Because of the need to provide immediate guidance to the public with respect to the procedures to be followed in filing a Notice of Intent to Terminate and with respect to the information which must be submitted with such Notice, I find that good cause exists for making these regulations effective immediately September 15, 1975.

Accordingly, Chapter XXVI of Title 29 of the Code of Federal Regulations is amended by adding a new Part 2604, reading as follows:

PART 2604—NOTICE OF INTENT TO TERMINATE

Sec.

AUTHORITY: Secs. 4002, 4041, Pub. L. 93-406, 88 Stat. 1004, 1020.

§ 2604.1 Purpose and scope.

(a) *Purpose.* The purpose of this part is to prescribe for non-multiemployer plans the contents of and procedures for filing the Notice of Intent to Terminate required by § 4041(a) of the Act.

(b) *Scope.* This part applies to terminations of non-multiemployer pension benefit plans covered by § 4021 of the Act. With respect to those plans, this part supersedes the interim rules governing Notices of Intent to Terminate which appeared at 39 FR 39163 (Sept. 3, 1974).

§ 2604.2 Defintions.

As used in this part—

"Act" means the Employee Retirement Income Security Act of 1974, 88 Stat. 1001 et seq.

"Active participants" means those participants who are currently employed, or on furlough, leave of absence, or lay-off, if the plan provides that such individuals continue to retain or accrue pension credits. A participant ceases to be an "active participant" upon incurring a break-in-service as provided by the plan, upon terminating employment with a right to a deferred vested benefit, or upon retiring under the terms of the plan.

"PBGC" means the Pension Benefit Guaranty Corporation.

§ 2604.3 Requirement of notice.

(a) *General.* A Notice of Intent to Terminate a plan to which this part applies shall be filed with the PBGC.

(b) *Who shall file.* The plan administrator, as defined in section 3(16) of the Act, or a duly authorized representative acting on behalf of the plan administrator, shall sign and file the Notice. A Notice submitted by a duly authorized representative, other than an attorney at law, shall be accompanied by a notarized power of attorney, signed by the plan administrator, which authorizes the said representative to sign and submit such a Notice, and, if desired, to act on behalf of the plan administrator in connection with the termination.

(c) *When to file.* A Notice required to be filed with the PBGC under the provisions of this part shall be delivered to the PBGC at least 10 days prior to the proposed date of termination of the plan.

(d) *Where to file.* A Notice or supplemental information required to be filed with the PBGC under the provisions of this part may be submitted by mail to the Office of Program Operations, Pension Benefit Guaranty Corporation, P.O. Box 7119, Washington, D.C. 20044, or may be submitted by hand to the Office of Program Operations, Pension Benefit Guaranty Corporation, 2020 K Street, NW., Washington, D.C.

(e) *Notice to employees.* Whenever a Notice is filed pursuant to this part, the plan administrator or his duly authorized representative shall immediately give written notification in the manner set forth below to the employees covered by the plan of the filing of the Notice. The notification shall state the date on which the Notice was filed and the date of termination proposed in the Notice. If the employees are represented by a union, the notification required by this section shall be delivered to the union representative. If the employees are not represented by a union, the notification shall be posted in the location or locations normally used by the employer for posting notices to employees.

(f) *Effect of failure to file.* Failure to file the Notice required by this part prior to the termination of a pension plan constitutes a violation of the provisions of Title IV of the Act.

§ 2604.4 Contents of notice.

(a) *General.* Each Notice required to be submitted pursuant to this part shall contain the information listed below. The response to each numbered item must be identified by item number. If any requested information is included in an Internal Revenue Service Form or submission attached to the Notice, that information need not be repeated in the body of the Notice. Instead, the information may be incorporated by reference to the number, date, and page or pages of the IRS Form or submission where it appears.

(b) *Information to be contained in notice.* Except as provided in paragraph (a) of this section, each Notice shall contain:

(1) The name, address, zip code and telephone number of the plan administrator and of the duly authorized representative, if any, of the plan administrator;

(2) The name of the plan;

(3) The name and address of the plan sponsor or sponsors, and, if different, of each employer employing plan participants, and the name and address of each trust under the plan;

(4) The nine-digit Internal Revenue Service Employer Identification Number assigned to each person identified in response to item (3);

(5) The three-digit Plan Number assigned to the plan by the sponsor or sponsors, or if applicable, by the employer or employers employing plan participants. If the plan has not previously been assigned a Plan Number, the terminating plan shall be given the number "001". If Plan Numbers have been assigned to other plans, the terminating plan should be assigned the three-digit number following the last number assigned;

(6) The nine-digit Internal Revenue Service Employer Identification Number of the trust, or trusts, established with respect to the plan;

(7) The name, address, and telephone number of every person, including a trust, holding or managing any plan assets;

(8) The number, if any, that had been assigned to the plan by the United States Department of Labor under the Welfare and Pension Plans Disclosure Act;

(9) The proposed date of termination of the plan, which date shall be no earlier than 10 days after the date the Notice is delivered;

(10) A copy of the document or documents establishing the plan;

(11) Copies of all amendments to the plan adopted or effective within the 5-year period preceding the proposed date of termination;

(12) A copy (or copies) of any group annuity or group insurance contracts or trust agreement (or agreements) providing for management of the assets of the plan, its administration, or the payment of benefits under the plan;

(13) The name, address and telephone number of each labor organization, if any, which represents employees who are participants in the plan; and the name and title of the principal officer, or officers, of that organization and/or of a labor organization of which it is a subordinate body, with whom the employer negotiates over matters relating to the plan;

(14) A complete copy of any collective bargaining agreement which contains provisions relating to the plan;

(15) A copy of the most recent actuarial statement and opinion (if any) relating to the plan;

(16) A copy of the most recent financial statement and opinion (if any) relating to the plan and, if that statement does not include a list of the assets of the

plan at market value, the latest available such list;

(17) A statement of any material change in the assets or liabilities of the plan occurring after the date of the actuarial and financial statements referred to in items (15) and (16);

(18) A copy of any request for a determination from the Internal Revenue Service with respect to the plan's termination;

(19) Complete copies of any letters of determination issued by the Internal Revenue Service relating to the establishment of the plan, any letters of determination relating to the disqualification of the plan and any subsequent requalification, and any letters of determination relating to the termination of the plan;

(20) Information as of the proposed date of termination concerning the number of participants and, for retired and disabled participants, the number of such participants and the aggregate monthly dollar amount of the benefits such participants are currently receiving from the plan compiled in the following tabular format:

ALL PARTICIPANTS

1. Active participants without vested rights.
2. Active participants with deferred vested rights.
3. Separated participants with deferred vested rights.
4. Retired and disabled participants and beneficiaries receiving payments from the plan.
5. Total.

ALL RETIRED AND DISABLED PARTICIPANTS

1. Number of participants and beneficiaries receiving benefits.
2. Aggregate amount of monthly benefit payments.

(21) Show the number of active participants who, if the plan were not terminated as of the proposed date of termination, would reasonably be expected to attain a nonforfeitable benefit under the terms of the plan (other than a benefit becoming nonforfeitable because of the termination of the plan) within the following number of days after the proposed date of termination.

30 days
60 days
90 days
120 days

(22) A statement of the reason for terminating the plan;

(23) A brief description of the proposed method of distributing the plan assets, *e.g.*, purchase of single premium annuities;

(24) A statement whether the plan assets are believed sufficient to satisfy all nonforfeitable benefits under the plan, other than those benefits which become nonforfeitable solely because of the termination of the plan.

(25) A statement whether any of the information required to be submitted pursuant to this section is of the nature that its disclosure may not be required pursuant to the Freedom of Information Act. The statement shall specify the information that may not be subject to disclosure and the grounds therefor;

(26) A certification that all information and documents submitted pursuant to Items (1) through (21), above, are true and correct to the best of the plan administrator's knowledge and belief.

(c) *Effect of failure to file all required information.* Failure to file any information required to be filed by this section shall render the Notice incomplete and it shall be voidable by the PBGC; *Provided*, That the Notice shall not be deemed incomplete and shall not be voidable by the PBGC if the PBGC pursuant to paragraph (d) of this section grants an extension of time to complete the filing or waives the obligation to file any information required by this section.

(d) *Extension of time or waiver of obligation to file information.* At the time of filing the Notice or prior thereto, the plan administrator or his duly authorized representative may request an extension of time to complete the filing or a waiver of the obligation to file any information required to be filed pursuant to this section. Such request shall be in writing, and state the reasons for the relief sought. A request for an extension of time shall also be accompanied by duplicate originals of an agreement signed by the plan administrator or his duly authorized representative, pursuant to which he agrees that if the PBGC grants such request, the 90-day period set forth in § 4041(a) of the Act during which the plan administrator may not make any distributions pursuant to the proposed termination of the plan shall be automatically extended by a period of time equal to the extension of time granted by the PBGC. When the PBGC grants an extension of time, it shall sign the agreement submitted with the request for extension and return the signed agreement to the plan administrator or his duly authorized representative.

§ 2604.5 Date of filing.

Any Notice or document required to be filed under the provisions of this part shall be deemed to have been filed on the date on which it is received by the PBGC.

§ 2604.6 Computation of time.

In computing any period of time prescribed or allowed by the rules of this part, the day of the act, event, or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, Sunday, or Federal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday, or Federal holiday.

Issued in Washington, D.C. on this 9th day of September, 1975.

JOHN T. DUNLOP,
Chairman, Board of Directors, Pension Benefit Guaranty Corporation.

[FR Doc.75-24488 Filed 9-12-75;8:45 am]

Title 38—Pensions, Bonuses, and Veterans' Relief

CHAPTER I—VETERANS ADMINISTRATION

PART 4—SCHEDULE FOR RATING DISABILITIES

Updating the Schedule for Rating Disabilities

On page 30502 of the FEDERAL REGISTER of July 21, 1975, there was published a notice of proposed regulatory development to amend Part 4, Title 38, Code of Federal Regulations, to update the Schedule for Rating Disabilities to reflect advances in medical science, modern surgery and new drug usage and to reflect changes in laws and interpretations of laws as well as changes in rating practice and procedures. In addition, more realistic evaluations for the epilepsies at various levels of disablement were provided.

Interested persons were given 30 days in which to submit comments, suggestions, or objections regarding the proposed regulations.

No written comments have been received and the proposed regulations are hereby adopted without change and are set forth below.

Effective date. An amendment to Appendix A, Table of Amendments and Effective Dates since 1946, is added to include effective dates.

The effective date is September 9, 1975.

Approved: September 9, 1975.

[SEAL] R. L. ROUDEBUSH,
Administrator.

1. Section 4.3 is revised to read as follows:

§ 4.3 Resolution of reasonable doubt.

It is the defined and consistently applied policy of the Veterans Administration to administer the law under a broad interpretation, consistent, however, with the facts shown in every case. When after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding the degree of disability such doubt will be resolved in favor of the claimant. See § 3.102 of this chapter.

2. Section 4.16 is revised to read as follows:

§ 4.16 Total disability ratings for compensation based on unemployability of the individual.

(a) Total disability ratings for compensation may be assigned, where the schedular rating is less than total, when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities: *Provided that*, if there is only one such disability, this disability shall be ratable at 60 percent or more, and that, if there are two or more disabilities, there shall be at least one disability ratable at 40 percent or more, and sufficient additional disability to bring the combined rating to 70 percent or more. For the above purpose of one 60 percent disabil-

ity, or one 40 percent disability in combination, the following will be considered as one disability: (1) Disabilities of one or both upper extremities, or of one or both lower extremities, including the bilateral factor, if applicable, (2) disabilities resulting from common etiology or a single accident, (3) disabilities affecting a single body system, e.g. orthopedic, digestive, respiratory, cardiovascular-renal, neuropsychiatric, (4) multiple injuries incurred in action, or (5) multiple disabilities incurred as a prisoner of war. It is provided further that the existence or degree of non-service-connected disabilities or previous unemployability status will be disregarded where the percentages referred to in this paragraph for the service-connected disability or disabilities are met and in the judgment of the rating agency such service-connected disabilities render the veteran unemployable.

(b) It is the established policy of the Veterans Administration that all veterans who are unable to secure and follow a substantially gainful occupation by reason of service-connected disabilities shall be rated totally disabled. Therefore, rating boards should submit to the Director, Compensation and Pension Service for extra-schedular consideration all cases of veterans who are unemployable by reason of service-connected disabilities, but who fail to meet the percentage standards set forth in paragraph (a) of this section. The rating board will include a full statement as to the veteran's service-connected disabilities, employment history, educational and vocational attainment and all other factors having a bearing on the issue.

3. Section 4.17 is revised to read as follows:

§ 4.17 Total disability ratings for pension based on unemployability and age of the individual.

All veterans who are basically eligible and who are unable to secure and follow a substantially gainful occupation by reason of disabilities which are likely to be permanent shall be rated as permanently and totally disabled. For the purpose of pension, the permanence of the percentage requirements of § 4.16 is a requisite. The percentage requirements, however, are reduced on the attainment of age 55 to a 60 percent rating for one or more disabilities, with no percentage requirements for any one disability. The requirement at age 60 through 64 will be a 50 percent rating for one or more disabilities. At age 65 and thereafter, a veteran is conclusively presumed to be permanently and totally disabled by statute; hence, rating action for this purpose is unnecessary. When the reduced percentage requirements are met, and the disabilities involved are of a permanent nature, a rating of permanent and total disability will be assigned if the veteran is found to be unable to secure and follow substantially gainful employment by reason of such disability. Prior employment or unemployment status is immaterial if in the judgment of the rating board the veteran's disabilities render him or her unemployable. In making such determinations, the following guidelines will be used:

(a) Marginal employment, for example, as a self-employed farmer, while employed in his or her own business, or at odd jobs or while employed at less than half the usual remuneration will not be considered incompatible with a determination of unemployability, if the restriction, as to securing or retaining better employment, is due to disability.

(b) Cases of all veterans who fail to meet the percentage standards but who meet the basic entitlement criteria and are unemployable, will be referred by the rating board to the Adjudication Officer under § 3.321(b)(2) of this chapter.

4. Section 4.17a is revised to read as follows:

§ 4.17a Misconduct etiology.

A permanent and total disability rating under the provisions of §§ 4.15, 4.16 and 4.17 will not be precluded by reason of the coexistence of misconduct disability when:

(a) A veteran, regardless of employment status, also has innocently acquired 100 percent disability, or

(b) Where unemployable, the veteran has other disabilities innocently acquired which meet the percentage requirements of §§ 4.16 and 4.17 and would render, in the judgment of the rating agency, the average person unable to secure or follow a substantially gainful occupation.

Meritorious cases of veterans meeting the specifications in this section except they do not meet the percentage standards of §§ 4.16 and 4.17, will be referred to Central Office under § 3.321(b) of this chapter.

5. Section 4.18 is revised to read as follows:

§ 4.18 Unemployability.

A veteran may be considered as unemployable upon termination of employment which was provided on account of disability, or in which special consideration was given on account of the same, when it is satisfactorily shown that he or she is unable to secure further employment. With amputations, sequelae of fractures and other residuals of traumatism shown to be of static character, a showing of continuous unemployability from date of incurrence, or the date the condition reached the stabilized level, is a general requirement in order to establish the fact that present unemployability is the result of the disability. However, consideration is to be given to the circumstances of employment in individual cases, and, if the employment was only occasional, intermittent, tryout or unsuccessful, or eventually terminated on account of the disability, present unemployability may be attributed to the static disability. Where unemployability for pension previously has been established on the basis of combined service-connected and non-service-connected disabilities and the service-connected disability or disabilities have increased in severity, § 4.16 is for consideration.

6. Section 4.27 is revised to read as follows:

§ 4.27 Use of diagnostic code numbers.

The diagnostic code numbers appearing opposite the listed ratable disabilities are arbitrary numbers for the purpose of showing the basis of the evaluation assigned and for statistical analysis in the Veterans Administration, and as will be observed, extend from 5000 to a possible 9999. Great care will be exercised in the selection of the applicable code number and in its citation on the rating sheet. No other numbers than these listed or hereafter furnished are to be employed for rating purposes, with an exception as described in this section, as to unlisted conditions. When an unlisted disease, injury, or residual condition is encountered, requiring rating by analogy, the diagnostic code number will be "built-up" as follows: The first 2 digits will be selected from that part of the schedule most closely identifying the part, or system, of the body involved; the last 2 digits will be "99" for all unlisted conditions. This procedure will facilitate a close check of new and unlisted conditions, rated by analogy. In the selection of code numbers, injuries will generally be represented by the number assigned to the residual condition on the basis of which the rating is determined. With diseases, preference is to be given to the number assigned to the disease itself; if the rating is determined on the basis of residual conditions, the number appropriate to the residual condition will be added, preceded by a hyphen. Thus, atrophic (rheumatoid) arthritis rated as ankylosis of the lumbar spine should be coded "5002-5289." In this way, the exact source of each rating can be easily identified. In the citation of disabilities on rating sheets, the diagnostic terminology will be that of the medical examiner, with no attempt to translate his or her terms into schedule nomenclature. Residuals of diseases or therapeutic procedures will not be cited without reference to the basic disease.

7. In § 4.71a, diagnostic codes 5174 and 5264 are added to read as follows:

§ 4.71a Schedule of ratings—musculoskeletal system.

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AMPUTATIONS: LOWER EXTREMITY

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	Rating
5174 Hip replacement (prosthesis):	
Prosthetic replacement of the head of the femur or of the acetabulum:	
For 1 year following implantation of prosthesis	100
Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches	[1] 90
Markedly severe residual weakness, pain or limitation of motion following implantation of prosthesis	70
Moderately severe residuals of weakness, pain or limitation of motion	50
Minimum rating	30

[1] Also entitled to special monthly compensation.

NOTE 1.—The 100 percent rating for 1 year following implantation of prosthesis will commence after initial grant of the 1 month total rating assigned under § 4.30 following hospital discharge.

NOTE 2.—Special monthly compensation is assignable during the 100 percent rating period the earliest date permanent use of crutches is established.

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THE KNEE AND LEG

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	Rating
5264 Knee replacement (prosthesis):	
Prosthetic replacement of knee joint:	
For 1 year following implantation of prosthesis	100
With chronic residuals consisting of severe painful motion or weakness in the affected extremity	60
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes, 5256, 5261, or 5262.	
Minimum rating	30

NOTE.—The 100 percent rating for 1 year following implantation of prosthesis will commence after initial grant of the 1 month total rating assigned under § 4.30 following hospital discharge.

8. Section 4.75 is revised to read as follows:

§ 4.75 Examination of visual acuity.

Ratings on account of visual impairments considered for service connection are, when practicable, to be based only on examination by specialists. Such special examinations should include uncorrected and corrected central visual acuity for distance and near, with record of the refraction. Snellen's test type or its equivalent will be used. Mydriatics should be routine, except when contraindicated. Funduscopic and ophthalmological findings must be recorded. The best distant vision obtainable after best correction by glasses will be the basis of rating, except in cases of keratoconus in which contact lenses are medically required. Also, if there exists a difference of more than 4 diopters of spherical correction between the two eyes, the best possible visual acuity of the poorer eye without glasses, or with a lens of not more than 4 diopters difference from that used with the better eye will be taken as the visual acuity of the poorer eye. When such a difference exists, close attention will be given to the likelihood of congenital origin in mere refractive error.

§ 4.81 [Revoked]

9. Section 4.81 is revoked.

10. Section 4.84 is revised to read as follows:

§ 4.84 Differences between distant and near visual acuity.

Where there is a substantial difference between the near and distant corrected vision, the case should be referred to the Director, Compensation and Pension Service.

11. In § 4.84a, the notes following diagnostic codes 6029 and 6080 are revised and diagnostic code 6035 is added to read as follows:

§ 4.84a Schedule of ratings—eye.

DISEASES OF THE EYE

* * * * *

	Rating
6029 Aphakia:	
Bilateral or unilateral	30

NOTE.—The 30 percent rating prescribed for aphakia is a minimum rating to be applied to the unilateral or bilateral condition and is not to be combined with any other rating for impaired vision. When only one eye is aphakic, the eye having poorer corrected visual acuity will be rated on the basis of its acuity without correction. When both eyes are aphakic, both will be rated on corrected vision. The corrected vision of one or both aphakic eyes will be taken one step worse than the ascertained value, however, not better than 20/70. Combined ratings for disabilities of the same eye should not exceed the amount for total loss of vision of that eye unless there is an enucleation or a serious cosmetic defect added to the total loss of vision.

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6035 Keratoconus: To be evaluated on impairment of corrected visual acuity using contact lenses.

NOTE.—When contact lenses are medically required for keratoconus, either unilateral or bilateral, the minimum rating will be 30 percent.

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RATINGS FOR IMPAIRMENT OF FIELD VISION

* * * * *

6080 Field vision, impairment of.

* * * * *

NOTE.—Demonstrable pathology commensurate with the functional loss will be required. The concentric contraction ratings require contraction within the stated degrees, temporally; the nasal contraction may be less. The alternative ratings are to be employed when there is ratable defect of visual acuity, or a different impairment of the visual field in the other eye. Concentric contraction resulting from demonstrable pathology to 5 degrees or less will be considered on a parity with reduction of central visual acuity to 5/200 or less for all purposes including entitlement under subparagraph (l), 38 U.S.C. 314; not, however, for the purpose of subparagraph (k). Entitlement on account of blindness requiring regular aid and attendance, subparagraph (m), will continue to be determined on the facts in the individual case.

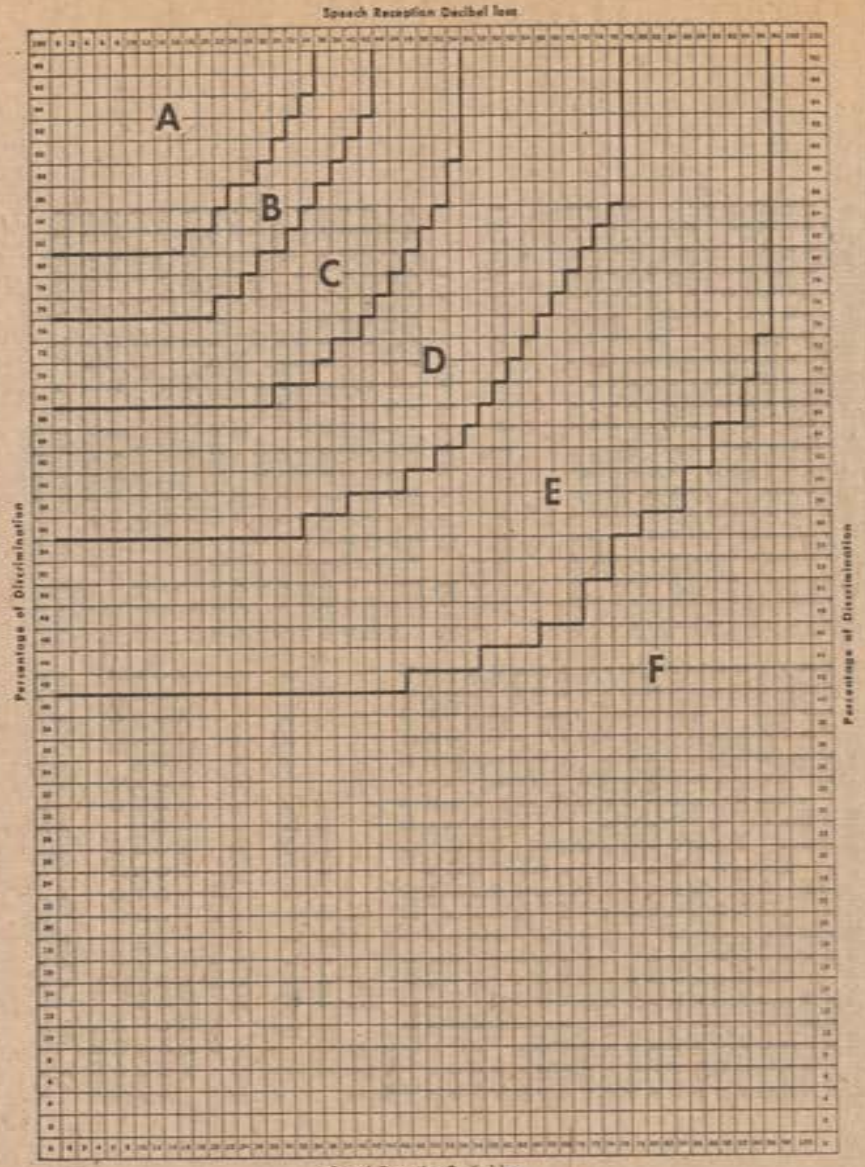
* * * * *

12. Section 4.87 is revised to read as follows:

§ 4.87 Conversational voice in feet.

The column and row containing entries in feet will not be used for the purpose of determining service connection or evaluation except in the rating of those unusual cases where no other data are available. In those cases showing no loss by spoken voice on induction but showing loss by spoken voice on discharge, evaluation will be deferred pending examination by controlled speech and pure tone apparatus. In those cases showing loss for spoken voice on induction, the footage equivalents on table II will be used to determine the extent of hearing loss at induction for comparison with the results of examination by controlled speech and pure tone.

TABLE I



(This chart showing the literal designation of hearing loss is based on the 1930 (ASSI) norm. No interpolation is required.)

TABLE II

Hearing in better ear			Hearing in poorer ear					
			Conversational voice in feet					
			0 feet	1 to 4 feet	5 to 7 feet	8 to 9 feet	10 to 14 feet	15 to 40 feet
Conversational	Pure tone audiometry average decibel loss at 3 frequencies: 500, 1,000 and 2,000 (either air conduction or PGSR)	Speech reception impairment literal designation	Pure tone audiometry decibel loss					
			Average 88 or more	Average not more than 87; none more than 95	Average not more than 67; none more than 80	Average not more than 45; none more than 60	Average not more than 33; none more than 45	Average not more than 25; none more than 35
			Speech reception impairment literal designation					
			F	E	D	C	B	A
0 feet	Average 88 or more	F	80 6277					
1 to 4 feet	Average not more than 87; none more than 95.	E	60 6278	60 6283				
5 to 7 feet	Average not more than 67; none more than 80.	D	40 6279	40 6284	40 6288			
8 to 9 feet	Average not more than 45; none more than 60.	C	30 6280	30 6285	20 6289	20 6292		
10 to 14 feet	Average not more than 33; none more than 45.	B	20 6281	20 6286	20 6290	10 6293	10 6295	
15 to 40 feet	Average not more than 25; none more than 35.	A	10 6282	10 6287	10 6291	0 6294	0 6296	0 6297

13. Section 4.87a is revised to read as follows:

§ 4.87a Diagnostic codes and literal designations.

	Rating
6277 Rated Column F, One Ear Row F, Other Ear Table II	[1] 80
6278 Rated Column F, One Ear Row E, Other Ear Table II	60
6279 Rated Column F, One Ear Row D, Other Ear Table II	40
6280 Rated Column F, One Ear Row C, Other Ear Table II	30
6281 Rated Column F, One Ear Row B, Other Ear Table II	20
6282 Rated Column F, One Ear Row A, Other Ear Table II	10
6283 Rated Column E, One Ear Row E, Other Ear Table II	60
6284 Rated Column E, One Ear Row D, Other Ear Table II	40
6285 Rated Column E, One Ear Row C, Other Ear Table II	30
6286 Rated Column D, One Ear Row B, Other Ear Table II	20
6287 Rated Column E, One Ear Row A, Other Ear Table II	10
6288 Rated Column D, One Ear Row D, Other Ear Table II	40
6289 Rated Column D, One Ear Row C, Other Ear Table II	20
6290 Rated Column D, One Ear Row B, Other Ear Table II	20
6291 Rated Column D, One Ear Row A, Other Ear Table II	10
6292 Rated Column C, One Ear Row C, Other Ear Table II	20
6293 Rated Column C, One Ear Row B, Other Ear Table II	10
6294 Rated Column C, One Ear Row A, Other Ear Table II	0
6295 Rated Column B, One Ear Row B, Other Ear Table II	10
6296 Rated Column B, One Ear Row A, Other Ear Table II	0
6297 Rated Column A, One Ear Row A, Other Ear Table II	0

[1] Entitled to special monthly compensation.

14. In § 4.97, diagnostic codes 6600, 6602, 6800 and 6802 are revised and diagnostic code 6603 is added so that the revised and added codes read as follows:

§ 4.97 Schedule of ratings—respiratory system.

* * * * *

DISEASES OF THE TRACHEA AND BRONCHI

	Rating
6600 Bronchitis, chronic:	
Pronounced; with copious productive cough and dyspnea at rest; pulmonary function testing showing a severe degree of chronic airway obstruction; with symptoms of associated severe emphysema or cyanosis and findings of right-sided heart involvement	100
Severe; with severe productive cough and dyspnea on slight exertion and pulmonary function tests indicative of severe ventilatory impairment	60
Moderately severe; persistent cough at intervals throughout the day, considerable expectoration, considerable dyspnea on exercise, rales throughout chest, beginning chronic airway obstruction	30
Moderate; considerable night or morning cough, slight dyspnea on exercise, scattered bilateral rales	10
Mild; slight cough, no dyspnea, few rales	0

* * * * *

	Rating
6602 Asthma, bronchial:	
Pronounced; asthmatic attacks very frequently with severe dyspnea on slight exertion between attacks and with marked loss of weight or other evidence of severe impairment of health	100
Severe; frequent attacks of asthma (one or more attacks weekly), marked dyspnea on exertion between attacks with only temporary relief by medication; more than light manual labor precluded	60
Moderate; asthmatic attacks rather frequent (separated by only 10–14 day intervals) with moderate dyspnea on exertion between attacks	30
Mild; paroxysms of asthmatic type breathing (high pitched expiratory wheezing and dyspnea) occurring several times a year with no clinical findings between attacks	10

NOTE.—In the absence of clinical findings of asthma at time of examination, a verified history of asthmatic attacks must be of record.

	Rating
6603 Emphysema, pulmonary:	
Pronounced; intractable and totally incapacitating; with dyspnea at rest, or marked dyspnea and cyanosis on mild exertion; severity of emphysema confirmed by chest X-rays and pulmonary function tests	100
Severe; exertional dyspnea sufficient to prevent climbing one flight of steps or walking one block without stopping; ventilatory impairment of severe degree confirmed by pulmonary function tests with marked impairment of health	60
Moderate; with moderate dyspnea occurring after climbing one flight of steps or walking more than one block on level surface; pulmonary function tests consistent with findings of moderate emphysema	30
Mild; with evidence of ventilatory impairment on pulmonary function tests and/or definite dyspnea on prolonged exertion	10

* * * * *

NONTUBERCULOUS DISEASES

	Rating
6800 Anthracosis (Black Lung Disease).	

* * * * *

	Rating
6802 Pneumoconiosis, unspecified:	
Pronounced; with extent of lesions comparable to far advanced pulmonary tuberculosis or pulmonary function tests confirming a markedly severe degree of ventilatory deficit; with dyspnea at rest and other evidence of severe impairment of bodily vigor producing total incapacity	100
Severe; extensive fibrosis, severe dyspnea on slight exertion with corresponding ventilatory deficit confirmed by pulmonary function tests with marked impairment of health	60
Moderate; with considerable pulmonary fibrosis and moderate dyspnea on slight exertion, confirmed by pulmonary function tests	30
Definitely symptomatic with pulmonary fibrosis and moderate dyspnea on extended exertion	10

* * * * *

15. In § 4.104, diagnostic codes 7005, 7015, 7101, 7110 are revised, a note has been added following diagnostic code 7111, and diagnostic code 7016 is added so that the revised and added codes read as follows:

§ 4.104 Schedule of ratings—cardiovascular system.

DISEASES OF THE HEART

* * * * *

	Rating
7005 Arteriosclerotic heart disease:	
During and for 6 months following acute illness from coronary occlusion or thrombosis, with circulatory shock, etc	100
After 6 months, with chronic residual findings of congestive heart failure or severe angina on mild exertion	100
Following typical history of acute occlusion or thrombosis, more than strictly sedentary employment precluded	80
Following typical history of acute coronary occlusion or thrombosis as above, or with history of substantiated repeated anginal attacks, more than light manual labor not feasible	60
Following typical coronary occlusion or thrombosis, or with history of substantiated anginal attack, ordinary manual labor feasible	30

NOTE.—Authentic myocardial insufficiency with arteriosclerosis may be substituted for occlusion.

* * * * *

	Rating
7015 Auriculoventricular block:	
Complete; with attacks of syncope necessitating the insertion of a permanent internal pacemaker, and for 1 year, after which period the rating will be on residuals as below	100
Complete; with Stokes-Adams attacks several times a year despite the use of medication or management of the heart block by pacemaker	60
Complete; without syncope or minimum rating when pacemaker has been inserted	30
Incomplete; without syncope but occasionally symptomatic	10
Incomplete; asymptomatic, without syncope or need for medicinal control after more than 1 year	0

NOTE 1.—Atrioventricular block, partial or complete, may be present associated with and related to the supraventricular tachycardias or pathological bradycardia. Cases with Mobitz Type II block may be encountered, as well as Wenckebach's phenomenon, Mobitz Type I block, and varying degrees of A–V block associated with tachyarrhythmias or other severe disturbances in rate or rhythm. Such unusual cases should be submitted to the Director, Compensation and Pension Service. On the other hand, simple delayed P–R conduction time, in the absence of other evidence of cardiac disease, is not a disability.

NOTE 2.—The 100 percent rating for 1 year following implantation of permanent pacemaker will commence after initial grant of the 1 month total rating assigned under § 4.30 following hospital discharge.

	Rating
7016 Heart valve replacement (prosthesis):	
For 1 year following implantation of prosthetic valve	100
Thereafter, rate as rheumatic heart disease; minimum rating	30

NOTE.—The 100 percent rating for 1 year following implantation of prosthetic valve will commence after initial grant of the 1 month total rating assigned under § 4.30 following hospital discharge.

DISEASES OF THE ARTERIES AND VEINS

* * * * *

	Rating
7101 Hypertensive vascular disease (essential arterial hypertension):	
Diastolic pressure predominantly 130 or more and severe symptoms	60
Diastolic pressure predominantly 120 or more and moderately severe symptoms	40
Diastolic pressure predominantly 110 or more with definite symptoms	20
Diastolic pressure predominantly 100 or more	10

NOTE 1.—For the 40 percent and 60 percent ratings under code 7101, there should be careful attention to diagnosis and repeated blood pressure readings.

NOTE 2.—When continuous medication is shown necessary for control of hypertension with a history of diastolic blood pressure predominantly 100 or more, a minimum rating of 10 percent will be assigned.

	Rating
7110 Aneurysm, aortic, fusiform, saccular, dissection and/or with stenosis:	
After establishment of diagnosis with markedly disabling symptoms; and for 1 year after surgical correction (with any type graft)	100

	Rating
If exertion and exercise is precluded	60
Thereafter, rate residual of graft insertion according to findings and symptoms under most appropriate analogy.	
Minimum rating	20

NOTE.—The 100 percent rating for 1 year following surgical correction will commence after initial grant of the 1-month total rating under § 4.30 assigned following hospital discharge.

7111 Artery, any large artery, aneurysm of.

* * * * *

NOTE.—Rate post-operative residuals with graft insertion under most appropriate analogy, e.g., 7116, etc., minimum rating 20 percent.

* * * * *

16. In § 4.114, diagnostic code 7347 is added to read as follows:

§ 4.114 Schedule of ratings—digestive system.

* * * * *

7347 Pancreatitis:	Rating
With frequently recurrent disabling attacks of abdominal pain with few pain free intermissions and with steatorrhea, malabsorption, diarrhea and severe malnutrition	100
With frequent attacks of abdominal pain, loss of normal body weight and other findings showing continuing pancreatic insufficiency between acute attacks	60
Moderately severe; with at least 4–7 typical attacks of abdominal pain per year with good remission between attacks	30
With at least one recurring attack of typical severe abdominal pain in the past year	10

NOTE 1.—Abdominal pain in this condition must be confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies.

NOTE 2.—Following total or partial pancreatectomy, rate under above, symptoms, minimum rating 30 percent.

17. In § 4.115a, diagnostic codes 7530 and 7531 are added to read as follows:

§ 4.115a Schedule of ratings—genitourinary system.

* * * * *

	Rating
7530 Chronic renal disease:	
Requiring regular hemodialysis	100
7531 Kidney transplant:	
For 2 years following transplant surgery	100
Thereafter: Rate residual symptoms under diagnostic code 7500, minimum rating	30

NOTE.—The 100 percent rating for 2 years following transplant surgery will commence after initial grant of the 1 month total rating assigned under § 4.30 following hospital discharge.

18. In § 4.117, diagnostic code 7714 is added to read as follows:

§ 4.117 Schedule of ratings—hemic and lymphatic systems.

* * * * *

7714 Sickle cell anemia:	Rating
Pronounced; with repeated painful crises, occurring in skin, joints, bones or any major organs caused by hemolysis and sickling of red blood cells with anemia, thrombosis and infarction, in symptom combinations that are totally incapacitating	100
Severe; with painful hemolytic crises several times a year or in symptom combinations less disabling than above with more than light manual labor not feasible	60
Moderately severe; following repeated hemolytic sickling crises but with only moderate impairment of health	30
Mild; asymptomatic, established case in remission, but with identifiable organ impairment present	10

NOTE.—Sickle cell trait alone without a history of or current pathological findings directly attributable to such trait is not a ratable disability. Cases of symptomatic sickle cell trait will be forwarded to the Director, Compensation and Pension Service for review.

19. In § 4.118, diagnostic code 7806 is revised to read as follows:

§ 4.118 Schedule of ratings—skin.

* * * * *

7806 Eczema:	Rating
With ulceration or extensive exfoliation or crusting, and systemic or nervous manifestations, or exceptionally repugnant	50
With exudation or itching constant, extensive lesions, or marked disfigurement	30
With exfoliation, exudation or itching, if involving an exposed surface or extensive area	10
With slight, if any, exfoliation, exudation or itching, if on a nonexposed surface or small area	0

* * * * *

20. In § 4.119, diagnostic code 7913 is revised to read as follows:

§ 4.119 Schedule of ratings—endocrine system.

* * * * *

7913 Diabetes mellitus:	Rating
Pronounced; uncontrolled, that is, with persistent hyperglycemia and glycosuria, despite large insulin dosage, restricted diet and regulation of activities; with progressive loss of weight and strength, or severe complications	100
Severe; requiring large insulin dosage, but with considerable loss of weight and strength and with mild complications, such as pruritis ani, mild vascular deficiencies, or beginning ocular disturbances	60
Moderately severe; requiring large insulin dosage, restricted diet, and careful regulation of activities, i.e., avoidance of strenuous occupational and recreational activities	40
Moderate; with moderate insulin or oral hypoglycemic agent dosage, and restricted (maintenance) diet; without impairment of health or vigor or limitation of activity	20
Mild; controlled by restricted diet, without insulin; without impairment of health or vigor or limitation of activity	10

NOTE.—Definitely established complications such as amputations, impairment of central visual acuity, peripheral neuropathy with definite sensory or motor impairment or definitely established arteriosclerotic focalizations will be separately rated under the applicable diagnostic codes. When the diagnosis of diabetes mellitus is definitely established it is neither necessary nor advisable to request glucose tolerance tests for rating purposes.

* * * * *

21. In § 4.124a, the "General Rating Formula for Major and Minor Seizures" in diagnostic code 8911 and "Epilepsy and Unemployability" in diagnostic code 8914 are revised to read as follows:

§ 4.124a Schedule of ratings—neurological conditions and convulsive disorders.

* * * * *

THE EPILEPSIES

* * * * *

8911 Epilepsy, petit mal:

* * * * *

	Rating
General Rating Formula for Major and Minor Epileptic Seizures:	
Averaging at least 1 major seizure per month over the last year	100
Averaging at least 1 major seizure in 3 months over the last year; or more than 10 minor seizures weekly	80
Averaging at least 1 major seizure in 4 months over the last year; or 9–10 minor seizures per week	60
At least 1 major seizure in the last 6 months or 2 in the last year; or averaging at least 5 to 8 minor seizures weekly	40
At least 1 major seizure in the last 2 years; or at least 2 minor seizures in the last 6 months	20
A confirmed diagnosis of epilepsy with a history of seizures	10

* * * * *

8914 Epilepsy, psychomotor.

* * * * *

Epilepsy and Unemployability: (1) Rating specialists must bear in mind that the epileptic, although his or her seizures are controlled, may find employment and rehabilitation difficult of attainment due to employer reluctance to the hiring of the epileptic.

(2) Where a case is encountered with a definite history of unemployment, full and complete development should be undertaken to ascertain whether the epilepsy is the determining factor in his or her inability to obtain employment.

(3) The assent of the claimant should first be obtained for permission to conduct this economic and social survey. The purpose of this survey is to secure all the relevant facts and data necessary to permit of a true judgment as to the reason for his or her unemployment and should include information as to:

(a) Education;

(b) Occupations prior and subsequent to service;

(c) Places of employment and reasons for termination;
(d) Wages received;
(e) Number of seizures.

(4) Upon completion of this survey and current examination, the case should have rating board consideration. Where in the judgment of the rating board the veteran's unemployability is due to epilepsy and jurisdiction is not vested in that body by reason of schedular evaluations, the case should be submitted to the Director, Compensation and Pension Service.

19. In § 4.132, the reference to notes at the beginning of diagnostic code 9406 is revised, Note (3) is revoked and Notes (4) and (5) redesignated (3) and (4) and diagnostic code 9504 is revised so that the revised material reads as follows:

§ 4.132 Schedule of ratings—mental disorders.

* * * * *

PSYCHONEUROTIC DISORDERS

* * * * *

9406 Psychoneurotic reaction, other.

Read well notes (1) to (4) following general rating formula before applying the general rating formula.

* * * * *

NOTE 3.—It is to be emphasized that vague complaints are not to be erected into a concept of conversion reaction. A diagnosis of conversion reaction must be established on the basis of specific distinctive findings characteristic of such disturbance and not merely by exclusion of organic disease. If a diagnosis of conversion reaction is found by the rating board to be inadequately supported by findings, the report of examination will be returned through channels to the examiner for reconsideration.

NOTE 4.—When two diagnoses, one organic and the other psychophysiologic or psychoneurotic, are presented covering the organic and psychiatric aspects of a single disability entity, only one percentage evaluation will be assigned under the appropriate diagnostic code determined by the rating board to represent the major degree of disability. When the diagnosis of the same basic disability is changed from an organic one to one in the psychophysiologic or psychoneurotic categories, the condition will be rated under the new diagnosis.

PSYCHOPHYSIOLOGIC DISORDERS

* * * * *

9504 Psychophysiologic reaction, other (specify reaction and manifestation).

Evaluate psychophysiologic reaction by the general rating formula for psychoneurotic disorders.

NOTE 1.—It is to be emphasized that vague complaints are not to be erected into a concept of psychophysiologic disorder. A diagnosis of a psychophysiologic reaction must be established on specific distinctive findings characteristic of such disturbance and not merely by exclusion of organic disease. If a diagnosis of a psychophysiologic reaction is found by the rating board to be inadequately supported by findings, the report of examination will be returned.

NOTE 2.—When two diagnoses, one organic and the other psychophysiologic or psychoneurotic, are presented covering the organic and psychiatric aspects of a single disability entity, only one percentage evaluation will be assigned under the appropriate diagnostic code determined by the rating board to represent the major degree of disability. When the diagnosis of the same basic disability is changed from an organic one to one in the psychophysiologic or psychoneurotic categories, the condition will be rated under the new diagnosis.

20. Appendix A, Table of Amendments and Effective Dates Since 1946, is amended to read as follows:

1. Section 4.71a is revised to read as follows:

4.71a Diagnostic Code 5000—60%; February 1, 1962.
Diagnostic Code 5000 Note (2): First three sentences; July 10, 1956. Last sentence; July 6, 1950.
Diagnostic Code 5002—100%, 60%, 40%, 20%; March 1, 1963.
Diagnostic Code 5003; July 6, 1950.
In sentence following DC 5024: "except gout which will be rated under 5002"; March 1, 1963.
Diagnostic Code 5164—60%; June 9, 1952.
Diagnostic Code 5172; July 6, 1950.
Diagnostic Code 5173; June 9, 1952.
Diagnostic Code 5174; September 9, 1975.
Diagnostic Code 5255 "or hip"; July 6, 1950.
Diagnostic Code 5257—Evaluations; July 6, 1950.
Diagnostic Code 5264; September 9, 1975.
Diagnostic Code 5297—(Removal of one rib) "or resection of 2 or more"; August 23, 1948.
Diagnostic Code 5297—Note (2): Reference to lobectomy, pneumonectomy and graduated ratings; February 1, 1962.
Diagnostic Code 5298; August 23, 1948.

2. Section 4.84a is revised to read as follows:

4.84a Diagnostic Code 6029—Note; August 23, 1948.
Diagnostic Code 6035; September 9, 1975.
Diagnostic Code 6076—60%; Vision 1 eye 15/200 and other eye 20/100; August 23, 1948.
Diagnostic Code 6080—Note—"as to 38 U.S.C. 314(L)"; July 6, 1950.
4.97 Diagnostic Code 6600—100% evaluations and criteria for 60%; September 9, 1975.
Diagnostic Code 6602—Criteria for all evaluations; September 9, 1975.
Diagnostic Code 6603; September 9, 1975.
Subparagraph (1) following Diagnostic Code 6704; December 1, 1949.
Subparagraph (j) following Diagnostic Code 6704; December 1, 1949.
Note preceding Diagnostic Code 6721; July 6, 1950.
Second note following Diagnostic Code 6724; December 1, 1949.
Diagnostic Code 6802—Criteria for all evaluations; September 9, 1975.
Diagnostic Code 6821—Evaluations and note; August 23, 1948.

3. Section 4.104 is revised to read as follows:

4.104 Diagnostic Code 7000—30%; July 6, 1950.
Diagnostic Code 7005—100% evaluation for chronic residuals; September 9, 1975.
Diagnostic Code 7015—100% evaluation, criteria all evaluations and Notes (1) and (2); September 9, 1975.
Diagnostic Code 7016; September 9, 1975.
Diagnostic Code 7100—20%; July 6, 1950.
Diagnostic Code 7101 "or more"; September 1, 1960.
Diagnostic Code 7101—Note (2); September 9, 1975.
Diagnostic Code 7110—criteria for 100%, Note and 60% and 20% evaluations; September 9, 1975.
Diagnostic Code 7111—Note; September 9, 1975.
Diagnostic Code 7114, 7115, 7116 and Note; June 9, 1952.
Diagnostic Code 7117 and Note; June 9, 1952.
Note following Diagnostic Code 7120; July 6, 1950.
Diagnostic Code 7121—Criteria for 30% and 10% and Note; July 6, 1950.
Last sentence of Note following Diagnostic Code 7122; July 6, 1950.

4. Section 4.114 is revised to read as follows:

4.114 Diagnostic Codes 7304 and 7305—Evaluations; November 1, 1962.
Diagnostic Code 7308—Evaluations; April 8, 1959.
Diagnostic Code 7319—Evaluations; November 1, 1962.
Diagnostic Code 7321—Evaluations and Note; July 6, 1950.
Diagnostic Code 7328—Evaluations and Note; November 1, 1962.
Diagnostic Code 7329—Evaluations and Note; November 1, 1962.
Diagnostic Code 7330—60% evaluation; November 1, 1962.
Diagnostic Code 7332—60% evaluation; November 1, 1962.
Diagnostic Code 7334—50% and 30% evalutions; July 6, 1950.
Diagnostic Code 7334—10% evaluation; November 1, 1962.
Diagnostic Code 7345—100%, 60% and 30% evaluations; August 23, 1948.
Diagnostic Code 7345—10% evaluation; February 17, 1955.
Diagnostic Code 7346—Evaluations; February 1, 1962.
Diagnostic Code 7347; September 9, 1975.

5. Section 4.115a is revised to read as follows:

4.115a Diagnostic Code 7500—Note; July 6, 1950.
Diagnostic Code 7524—Note; July 6, 1950.
Diagnostic Code 7530; September 9, 1975.
Diagnostic Code 7531; September 9, 1975.

6. Section 4.117 is revised to read as follows:

4.117 Diagnostic Code 7703—Evaluations; August 23, 1948.
Diagnostic Code 7709—Evaluation and Note; June 9, 1952.
Diagnostic Code 7714; September 9, 1975.

7. Section 4.119 is revised to read as follows:

4.119 Diagnostic Code 7911—Evaluations and Note; March 1, 1963.
Diagnostic Code 7913—Note; September 9, 1975.

8. Section 4.124a is revised to read as follows:

4.124a Diagnostic Code 8045; October 1, 1961.
Diagnostic Code 8046; October 1, 1961.
Diagnostic Code 8100—Evaluations; June 9, 1953.
Diagnostic Codes 8910 through 8914; October 1, 1961.
Diagnostic Codes 8910 through 8914 General Rating Formula—Criteria and evaluations; September 9, 1975.

[FR Doc.75-24506 Filed 9-12-75;8:45 am]

Title 39—Postal Service

CHAPTER I—U.S. POSTAL SERVICE

PART 111—GENERAL INFORMATION ON POSTAL SERVICE

Solicitations by Mail in the Guise of Bills, Invoices, or Statements of Account

On November 22, 1972, at the conclusion of a public rulemaking proceeding,